MEDICAL CARE ADVISORY COMMITTEE

Minutes of the September 20, 2012 Meeting

IN ATTENDANCE

PRESENT: Lincoln Nehring, Andrew Riggle, LaPriel Clark, Judi Hilman, Warren Walker, Russ Elbel, Tina Persels, Mauricio Agramont, Mark E. Ward, Michael Hales

EXCUSED: Jason J. Horgesheimer, Pasu Pasupathi

ABSENT: E. David Ward, LaVal B. Jensen, Michelle McOmber, Greg Myers, Kevin Burt, Rebecca Glather

STAFF: Jeff Nelson, Nate Checketts, Eric Grant, Tonya Hales, Julie Ewing, Emma Chacon, Aaron Eliason, John Strong, Josip Ambrenac, Gayle Coombs

VISITORS: Janida Emerson, Beau Colvin, Jerry Petersen, Joyce Dolcourt, Andrea Smardon, Scott Sherratt, Barb Viskochil, Chad Westover, Nalaui Namauu, Matt Stowaker, Russ Frandsen

1. **Welcome** – Lincoln Nehring

Chairman Nehring called the meeting to order at 1:35 p.m. and welcomed everyone. He then presented Gerald Petersen with a plaque for his years of service on the MCAC Committee and thanked him for all his hard work with the Committee. Gerald said it was a very nice six years that he had with the MCAC and thanked everyone for all their support during that time.

Approve Minutes of July 26, 2012 Meeting

Chairman Nehring then asked if we could now approve the minutes. Mark Ward made the motion to approve the minutes and Warren Walker seconded the motion. The minutes were approved by everyone.

Chairman Nehring then introduced Josip Ambrenac who will be replacing John Strong and will be the new MCAC Manager for coordination purposes.

Vote for New Vice-Chair and At-Large Executive Committee Members

Chairman Nehring then said we need to get a new Vice-Chairman from the Provider Community for the MCAC Executive Committee (EC). Russ Elbel volunteered for this assignment. There were no other nominations. Judi Hilman moved that Russ be the Vice-Chairman of the MCAC. Everyone agreed and Russ will be the new Vice-Chairman.

Chairman Nehring said we also need an At-Large position filled. Warren Walker volunteered for this position. Judi Hilman made the motion and everyone approved that Warren Walker become the new At-Large Member of the MCAC EC.

2. **New Rulemakings** - Craig Devashrayee

Craig then went over the DMHF Rules Matrix 9-20-12.

Rule; (What It Does); Comments.	File	Effective
R414-1-5 Incorporations by Reference; Subsection 26-18-3(2)(a) requires the Medicaid program to implement policy through administrative rules. The Department, in order to draw down federal funds, must have an approved State Plan with the Centers for Medicare and Medicaid Services (CMS). The purpose of this change, therefore, is to incorporate the most current Medicaid State Plan by reference and to implement by rule both the definitions and the attachment for the Private Duty Nursing Acuity Grid found in the Home Health Agencies Provider Manual, and to implement by rule ongoing Medicaid policy for services described in the Utah Medicaid Provider Manual, Medical Supplies Manual and List; Hospital Services provider Manual; Speech-Language Services Provider Manual; Audiology Services Provider Manual; Hospice Care Provider Manual; Long Term Care Services in Nursing Facilities Provider Manual; Personal Care Provider Manual; Utah Home and Community-Based Waiver Services for Individuals 65 or Older Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Acquired Brain Injury Age 18 and Old Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Intellectual Disabilities or Other Related Conditions Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Physical Disabilities Provider Manual; Utah Home and Community-Based Waiver Services New Choices Waiver Provider Manual; Utah Home and Community-Based Waiver Services for Technology Dependent, Medically Fragile Individuals Provider Manual; the Office of Inspector General Administrative Hearings Procedures Manual; and the Pharmacy Services Provider Manual (Updates to July 1, 2012). This amendment also clarifies that provider appeals of action initiated by the Office of Inspector General of Medicaid Services (OIG) are governed by the OIG Administrative Hearings Procedures Manual.	**6-15-12**	**8-10-12**
R414-49 Dental Services; The purpose of this change is to clarify that limited emergency dental services, as mandated by the Legislature, are based on the Early and periodic Screening, Diagnosis and Treatment (EPSDT) Program.	**6-15-12**	**8-10-12**
R414-50 Dental, Oral and Maxillofacial Surgeons; The purpose of this change is to clarify that limited emergency dental services, as mandated by the Legislature, are based on the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.	**6-15-12**	**8-10-12**
R414-60A Drug Utilization Review Board (Five-Year Review); This rule is necessary because it implements the composition and membership requirements of the DUR Board to provide medically necessary and cost effective services for Medicaid recipients. This rule also spells out the functions of board members to carry out their responsibilities for the Medicaid drug program. Therefore, this rule should be continued.	**6-25-12**	**6-25-12**
R382-2 Electronic Personal Medical Records for the Children's Health Insurance Program; House Bill 46, 2012 General Session, requires the Department to implement by rule a program to enroll individuals who receive services under the Children's Health Insurance program (CHIP) in the Clinical Health Information Exchange (cHIE). The bill also requires the Department to notify these individuals of their right to opt out of cHIE. This rule describes the process the Department will use to enroll individuals in cHIE.	**7-2-12**	**9-1-12**
R414-8 Electronic Personal Medical Records for the Medicaid Program; House Bill 46, 2012 General Session, requires the Department to implement by rule a program to enroll individuals who receive Medicaid services in the Clinical Health Information Exchange (cHIE). The bill also requires the Department to notify these individuals of their right to opt out of cHIE. This rule describes the process the Department will use to enroll individuals in cHIE.	**7-2-12**	**9-1-12**
R414-60B Preferred Drug List (Five-Year Review); This rule is necessary because it implements the composition and membership requirements of the P&T Committee to provide medically necessary and cost effective services for Medicaid recipients. This rule should also be continued because it spells out the functions of committee members to carry out their responsibilities for the Medicaid drug program.	**7-30-12**	**7-30-12**
R414-308-3 Application and Signature; This amendment changes the application date for applications submitted through the online myCase application process so the date of application is the date in which the applicant submits the online application to the Department of Workforce Services.	**7-31-12**	**10-1-12**
R414-310 Medicaid Primary Care Network Demonstration Waiver; This amendment adds insurance that an employer offers through Utah Health Exchange as a form of creditable health insurance. It also adds, clarifies, and deletes certain definitions, clarifies effective dates, and makes other minor corrections.	**7-31-12**	**10-1-12**
R414-320 Medicaid Health Insurance Flexibility and Accountability Demonstration Waiver; This amendment adds insurance that an employer offers through Utah Health Exchange as a form of creditable health insurance. It also adds, clarifies, and deletes certain definitions, clarifies effective dates, and clarifies reenrollment and benefits in Utah's Premium Partnership for Health Insurance (UPP) program. It further removes the requirement for children to apply for UPP only during an open enrollment period and makes other minor corrections.	**7-31-12**	**10-1-12**
R414-320-10 Income Provisions; This amendment increases the income limit from 150% of the federal poverty level to 200% of the federal poverty level to qualify for UPP assistance.	**7-31-12**	**10-1-12**
R414-502 Nursing Facility Levels of Care (Repeal and Reenact); The purpose of this change is to modify the level of care for intermediate care facilities for persons with intellectual disabilities (ICFs/ID) to incorporate a new definition of autism spectrum disorders. All requirements of the repealed rule are reenacted in the proposed rule. In contrast to the repealed rule, this new rule removes the description of obsolete levels of care and modifies the level of care for ICFs/ID by incorporating the new definition of autism spectrum disorders. It further replaces the previous term of disability with the appropriate term of "intermediate care facilities for persons with intellectual disabilities."	**7-31-12**	**9-21-12**
R414-15 Residents Personal Needs Fund (Five-Year Review); This rule is necessary because it establishes requirements for long-term care facilities to manage and safeguard a resident's personal funds.	**8-20-12**	**8-20-12**

R414-22 Administrative Sanction Procedures and Regulations; This amendment grants discretionary authority to the Department and to the Provider Sanction Committee to sanction providers for current and past misconduct.	**8-31-12**	**10-22-12**
R414-510-4 Program Access Requirements (Change in Proposed Rule); Based on public comments received by the Department, the purpose of this change is to clarify the notification and application process for the Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) Transition Program.	**8-31-12**	**10-22-12**

Chairman Nehring had a question in regard to R414-320 and the UPP changes. Michael Hales and Jeff Nelson both provided appropriate answers to the question.

John Curless said that in regard to R414-49 and R414-50, this is the change where they are adding emergency dental for non-pregnant adults.

Russ also had a question in regard to provider sanctions and the committee that handles this. Michael Hales said it is Dr. Patton and a few other people who review these cases from providers. Michael Hales said if we could pull out the finding from the Office of Inspector General, this could help and would give us the full basis for it. Emma Chacon explained how this is given to the Bureau Director and then they give it to Michael Hales. She said these things happen very rarely.

Judi had some comments on R414-60B. This was in regard to the Preferred Drug List. Michael Hales said the existing structure we have in place is still sufficient for what we were accomplishing under the Accountable Care Organization (ACO) model. Medicaid does have a Drug Utilization Review (DUR) Board and a Pharmacy and Therapeutics (P&T) Committee. The P&T Committee does have a reporting relationship to the Drug Utilization Review (DUR) Board, and the plan has been from the beginning that the ACO Organizations will present their individual P&T Committee's review of their Preferred Drug List (PDL) to the Drug Utilization Review (DUR) Board to have on file and possibly for an agenda topic. Michael Hales indicated that this would not happen through the State's P&T Committee, as our P&T Committee is just for the Medicaid Preferred Drug List (PDL). Michael said the Drug Utilization Review Board (DUR), which is oversight to the P&T Committee, would be the one to get the information from the Accountable Care Organizations.

3. **Budget Update** – Eric Grant for Tracy Luoma

Eric Grant said the total Medicaid enrollment went up from last month. Russ Elbel asked if Eric Grant could explain why one month we will go up and the next month we will go down. Eric Grant said they are looking at why the increases and decreases occur each month. Eric Grant did say a lot of this is children.

The total enrollment for August was 253,188. On the report it shows that the number of People over age 65 went up by 40, the number of People with Disabilities went up by 219, the number of Children went up by 1,266, the number of Pregnant Women went down by 97, and the number of Adults went up by 358.

4. **Director's Report** – Michael Hales

MMIS Project Update

Michael Hales mentioned how the State is looking at replacing its current Medicaid claims payment system. The current system is about 30 years old, so we are replacing our current system. CNSI is the new vendor for handling looking at the new system and putting it together. CNSI will be transferring

their existing system with the State of Washington to Utah. We are hoping that about 30% of the Washington system will be reusable. Very shortly, we will be starting the contract negotiation process with CNSI. We hope to have the contract in place by January of next year. Once this is put in place, no additional Federal matching funds are paid until the system has been certified by CMS.

There will also be an IV&V Contract for Independent Verification & Validation of the MMIS System. The IV&V Vendor will be working side by side with the programming firm. Currently, six bids are being reviewed. We will want to be sure that the provider community is involved in the testing of this new system as we are in development and doing user acceptance testing. A question was asked about MMCS. MMCS stands for Medicaid Managed Care System and is a sub-system of MMIS. As appropriate, additional updates will be provided to the MCAC.

Building Block Process

Michael Hales explained that the Department has gone through the building block process and is working on coming up with a final document on this. The Governor's Office of Planning and Budget will present its budget proposal the first or second week of December. UDOH's building blocks are not yet finalized.

Utah's Uninsured Numbers

Michael Hales said a report was issued by the Department of Health on August 27th showing the new number of uninsured. The numbers went up this year. BRFSS is a survey that is done on this. As a result of this survey and using a few changes in their methodology, the number of uninsured is 377,700. 13.47% of the population is uninsured in Utah. A lot of the calculations in regard to expanding Medicaid or not expanding Medicaid will be made in regard to this.

Judi Hilman requested a copy of the survey results and Nate Checketts agreed to make this information available to the MCAC.

Michael explained some things in regard to CHIP enrollment and what is looked at. There are three different enrollment groups in CHIP. Emma Chacon said some of the people that go off of CHIP do it because now they have private insurance. Judi Hilman had a question in regard to some information that came out saying how the unemployment rate has gone up in Utah. Michael Hales said he really has no additional information in regard to this now. He said we have been steadily seeing a rise in the number of people needing insurance. Barbara Viskochil asked if we have the data by zip code, and Nate Checketts said we did not have it by zip code that he knew of. Michael Hales said the standard way to share information is at the statewide level.

5. **ACO Contract Discussion** – Michael Hales

Michael Hales said in the 2011 Legislative Session, the Legislature passed unanimously SB-180, which directed the Department to put in place a new waiver program with specific provisions. Medicaid has submitted a waiver document to the Federal Government for consideration. Originally, we had been targeting July 1 of this year for implementation, but because of the delay in getting the approval of this, the target date has been put off to October 1. After looking at it more, it was decided that October 1 would be too soon, so this has been postponed to January 1, 2013 for the implementation. Currently,

there are four contractors along the Wasatch Front working on the ACO implementation. The focus was to move to a system that focuses on quality.

Michael Hales mentioned some of the changes we have been working on implementing. We wanted to use base line quality data. We have historical data from some of the plans that we have been working with over the past years. We are going to keep these same quality measures in place as we transition from the current contract towards going into the new program January 1, 2013. After we implement the new ACO model in January 2013, the Department would engage in a public process for determining and creating new quality measures under this new model. There are some things we may need to have safe guards for that we don't currently have today. We are committed to doing this.

There have been some questions come up about the contracts themselves. There was a meeting a few weeks ago to discuss the ACO contracts and if there were some things that needed to be changed or done before they go live January 1, 2013. Judi Hilman organized this meeting.

Judi Hilman passed out a document entitled Utah Health Policy Project. She mentioned that until it is all done, maybe it should be called something rather than ACO. Maybe it could be called Risk-Based Managed Care Contract Specifications for Utah's Transition to Accountable Care or something like that. Judi said she feels the policy makers need to be made more aware of the ACO. She said we should look at other states to see what they have done with this.

Michael Hales said we are very much in support of having a structure and a time line. He mentioned some things they are looking at in regard to moving on with this. Michael said it will take a while to get this developed. He said we are still very committed to doing this.

Michael Hales said in terms of the name ACO, he said there are a lot of different things we could call this but the main focus on this when it started was the accountability part of it. Michael said he does not feel there is an inconsistency in what we are doing with the name. Michael had comments in regard to what Judi suggested. He explained where he feels the State needs to be moving in regard to all this. The State has to have contracts and plans in line within certain times.

Michael Hales put it out to the MCAC to see if there were any comments from the other members of the MCAC in regard to this program being called ACO. Judi Hilman explained why she does not feel this should be called Accountability Care until we have certain things in place. The quality targets in regard to this were mentioned, and Michael Hales said we do have base line quality targets based on historical delivery of care, and those are the targets we are having in place. Michael said he feels we need to focus more on putting this into place rather than changing the name. Andrew Riggle had a question in regard to what we end up developing. Michael Hales said a lot of the contract that we are moving forward has been being done by the Department over the last 15 years. This is a Managed Care-based accountable care operation. We can go through this process and figure out what the key things are to measure and what we are really looking to purchase.

The Department is in the process of submitting a request for a grant to add quality measures to this program. This was in response to a question from Chairman Nehring. Michael Hales said he feels we will need some grant funding up front to do some of the things and implement some of the things we will want to do.

Andrew Riggle asked if there was enough flexibility within the contracts for the measures to be integrated with existing contracts or would we have to wait for the next contract period. Michael Hales said if we are just implementing new quality measures from some point forward, if there was enough lead time to do this, it could be done. Emma Chacon said we can make amendments to the contract up until the first of the year. She said we currently have staff that can look at all the measures and would decide how we are going to collect them.

LaPriel Clark said she feels like the document Judi Hilman passed out should be reviewed first by everyone before it is voted on. Judi Hilman said they will be having a meeting in regard to all this. Judi mentioned that her motion would be to change the name from an Accountable Care Organization contract to Risk-Based Managed Care Contract Specifications for Utah's Transition to Accountable Care. No one seconded the motion.

Chairman Nehring then asked a question regarding marketing materials. Michael Hales said marketing had been discussed before to have all marketing materials put out by provider plans come before the MCAC for review before anything was done with them. Michael Hales said he feels the MCAC should review all marketing materials. Emma Chacon said there is a Federal regulation that the CHIP Advisory Council should approve these materials for the CHIP Program. Marketing materials could be put on the MCAC agenda for the next meeting and then the MCAC could contemplate this and vote on it. The marketing is for getting people on the program, not for distinguishing one provider from another. Russ Elbel said he feels this would be very helpful, but he would like to learn more about the process with CHIP on this.

Andrew Riggle said he liked the idea of bringing this for future discussion to the next MCAC meeting. Andrew Riggle asked if any of this would have an impact on the ACO's transition to the program. Chad Westover from Molina had some comments in regard to this. He said he thinks this new plan would be good. Chad Westover said he feels if we had ground rules in regard to this, it could save us a lot of discussion and questions. It was suggested that the MCAC develop a sub-committee that could look into these things more and then bring it back to the main MCAC Committee. Chairman Nehring said it was almost 3:30 p.m. and said we could bring this back to the next MCAC Meeting.

6. **<u>Other Business</u>** – MCAC Members

There was no other business, so Chairman Nehring adjourned the meeting at 3:30 p.m.